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ABSTRACT

This study focused on: (1) emotional and behavioral symptomatology in children and their mothers following a disclosure of child sexual abuse; (2) the role of victimization experiences in the symptomatology; (3) connections between mothers' and children's experiences of emotional distress following sexual abuse disclosure; (4) differences in agreement between mothers and children on the level of symptomatology the children experienced; and (5) the role of maternal symptomatology in the closeness of mother-child agreement. Participants were 49 sexually abused children between 6 and 12 years of age and their mothers. Findings indicated that maternal adjustment following disclosure affected not only children's adjustment, but also mothers' ability to separate their own emotional experience from their children's. It is concluded that these findings argue for a family perspective in interventions for children who have been sexually abused. (28 references) (RH)

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MOTHERS AND CHILDREN FOLLOWING SEXUAL ABUSE DISCLOSURE: CONNECTIONS, BOUNDARIES, AND THE EXPRESSION OF SYMPTOMATOLOGY

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ABSTRACT

This paper examines the effects of child sexual abuse on mothers as well as on their children. Maternal adjustment following disclosure appears to affect not only their children's adjustment, but also mothers' ability to separate their own from their children's emotional experience. These findings argue for a family perspective in child sexual abuse interventions.

A growing literature suggests that child sexual abuse has reached epidemic proportions, and that the consequences to the child are both long-lasting and severe (e.g: Herman, Russell, & Trocki, 1986; Gomes-Schwartz, Horowitz, & Sauzier, 1985; Gelinas, 1983). Mothers of sexually abused children have been largely ignored in the literature, or have been treated as agents of abuse in incestuous families or as contributors to children's poor outcomes (Caplan & Hall-McCorquodale, 1985; De Jong, 1988; Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989).

Mothers, however, also suffer in their own right from disclosures of their children's abuse. It is noteworthy that the Diagnostic and Statistical Manual of Mental Disorders-III-Revised defines Post Traumatic Stress as a disorder that results not only from a threat or harm to the self, but also as "...a serious threat or harm to ones children... (American Psychiatric Association, 1987, p. 247)."

While it is important to recognize the emotional consequences to mothers of their children's sexual abuse, one must also acknowledge that maternal distress undoubtedly also contributes to their children's subsequent adaptation.

A connection between parental distress and children's adaptation has been documented in the mental health literature (e.g: Billings & Moos, 1983; Griest, Forehand, Wells, & McMahon, 1980). Children of depressed mothers, for example, exhibit higher levels of symptomatology than children in normative samples (Downey, & Coyne, 1990). It has been suggested that the recovery of sexually abused children is similarly influenced by maternal well-being and response to the child (Conte, 1985; 1987; Newberger & De Vos, 1988).

Mothers' emotional functioning following disclosure also has implications for professional understanding of the child's experience. Much of the information in the literature about the effects of sexual abuse on children has rested on maternal report (e.g: Friedrich, Urquiza, & Beilke, 1986). Distress or denial may affect how mothers report the behavior and feelings of others.

Recently the accuracy of maternal report has come into general question. For example, there is some evidence that depressed mothers report higher depression symptoms in their children than do nondepressed mothers (Kazdin, Esveldt-Dawson, Sherick & Colbus, 1985). However, it is unclear whether this is due to distortions in perception or to higher levels of depression in these children (Richter & Pellegrini, 1989).

Poor agreement between maternal report on the Child Behavior Checklist and other reporters has also been found (e.g., Achenbach, McConaughy & Howell, 1987). Several studies have found that mothers vary in the accuracy of their perceptions. For example, an examination of differences in maternal report of nonclinic and behavior-problem clinic-referred children found that maternal perceptions of child behavior in the nonclinic group was best predicted by child behavior, whereas in the clinic group maternal report was best predicted by the interaction between maternal adjustment and child behavior (Griest, Forehand, Wells, & McMahon, 1980). In a recent study of maternal support following incest, mothers who did not believe incest occurred were less accurate reporters of their children's symptomatology than mothers who gave credence to their children's report (Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989).

These studies suggest that the consequences of child sexual abuse, and relationships between mothers and their children following disclosure are complex and multifaceted. This paper explores the effects of victimization on mothers and their children, how their distress is connected, and how it may serve to create boundaries between them.

This study has three primary objectives:

1) to describe emotional and behavioral symptomatology in both children and their mothers following a disclosure of child sexual abuse and the role of victimization experiences in that symptomatology;

2) to examine connections between mothers' and their children's experiences of emotional distress following sexual abuse disclosure; and

3) to explore differences in agreement between mothers and their children on the level of symptomatology the children experience, and the role of maternal symptomatology in the closeness of mother -child agreement.

METHOD

Subjects

Participants were 49 sexually abused children ages six through 12 and their mothers. The sample included 69 percent girls (34) and 31 percent boys (15). Seventy-three percent (36) are white and 27 percent are African-American (10) or Hispanic (3) distributed evenly across levels II through V of Hollingshead's (1979) four-factor index of social status. The mean age is 8.6 years.

All but one child was living with the biological or adoptive family at the time of enrollment into the study. No significant relationships were found between ethnicity, gender, age, and socioeconomic status (SES).

Procedures

Subjects were recruited from Children's Hospital in Boston and from district attorneys' offices in the greater Boston area following a disclosure of sexual abuse. In Massachusetts, it should be noted, all substantiated cases of child sexual abuse are referred by law to the local district attorney.

Of families contacted, 64 percent agreed to participate. Analyses of anonymous background data collected on all children eligible for the study indicate that children who did and did not participate were comparable on age, gender, race, and SES.

The data presented are part of a larger longitudinal study designed to assess children's emotional functioning at six month intervals during the year following disclosure. The present analysis presents data from the first of the three interviews, which was obtained within two to four months following disclosure in all but a few cases. Two-person female interviewer teams interviewed mothers and children in their homes. Interviewers were professionals from either social work or special education backgrounds trained in the administration of the measures used in this study.

Measurement.

Demographic data. Family background information was collected on a questionnaire developed for this study. Demographic variables used in this analysis include age and gender of child, educational and occupational background of parents, and ethnicity of family members.

Victimization data. Victimization information was collected from the mother on a detailed questionnaire designed for this study. Victimization data were not collected from children due to concerns of the cooperating district attorneys that information provided by the child in a research context might be discoverable in a legal action or might interfere with the child's participation in the investigative process.

Because details of victimization may be revealed over time, the questionnaire was repeated at the six-month and twelve-month interviews. Information from the three questionnaires was used to code the victimization variables.

Four victimization variables were used in the analysis: Severity; Force; Duration; and

Perpetrator.

Severity was a scored variable that summarized the acts involved in the abuse. To construct the score, experts rated each of ten acts for its impact on a child on a scale from zero (low impact) to two (severe impact). Their averaged scores provided the following value for each act: genital exposure = 0.5; kissing, fondling, and masturbation = 1.0; oral-genital contact and digital or object penetration = 1.5; anal or vaginal intercourse = 2. The sum of the scores of each reported act yields the severity score. If every act had been performed, the score would be 7.5.

Force was coded into three categories: no use of force = 1; threat of force = 2; use of force = 3.

Duration was a continuous variable expressed in days. Because of the extreme skewness of the variable (e.g., eighteen children abused once; one child abused more than five years), duration was coded as follows: a single act = 1; two - 30 days = 2; 31 days to one year = 3; over one year = 4.

Perpetrator was expressed as a dichotomous variable: intrafamilial and extrafamilial. Abuse by a biological father, father figure such as step-father or mother's boyfriend, uncles, cousins, and siblings was coded intrafamilial. Abuse by an unknown or known perpetrator with no familial relationship was coded extrafamilial. Cases with multiple perpetrators where at least one perpetrator was intrafamilial was coded as intrafamilial. For some analyses perpetrators were dichotomized into father figures (adopted, biological, step, or mother's boyfriend) and other.

Outcome measures. Child outcomes were assessed through two child self-report measures of affective symptomatology, the Children's Depression Inventory (CDI) (Kovacks, 1981) and the Revised Children's Manifest Anxiety Scale (RCMAS) (Reynolds & Richmond, 1985), and also through maternal report on the Child Behavior Checklist (Achenbach and Edelbrock, 1983). Maternal outcome was measured on the Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982). Outcome measures are presented in Table One.

Insert Table One about here

All questionnaires are read to the respondent in order to avoid any bias due to reading ability.

The *Revised Children's Manifest Anxiety Scale* contains 37 sentences describing a thought or feeling (e.g., "My hands feel sweaty."). The child responds yes or no depending on whether the

item is perceived as applying to the self. A Total Anxiety T score based on the sum of affirmative responses is calculated by race, age, and gender. Internal consistency estimates give an alpha coefficient above .80 across a variety of normal and exceptional samples (Reynolds & Richmond, 1985). Test-retest reliabilities have been reported at .98 at three weeks and at .68 at nine months (Reynolds, 1981; Pela & Reynolds, 1982).

The RCMAS also yields a Lie subscale score. The authors suggest caution when both the Total Anxiety T and the Lie T scores fall one standard deviation or more above the mean (Reynolds & Richmond, 1985). The two children in the sample who fulfilled these criteria were not included in analyses using this measure.

In this study, the Total Anxiety T score is used as a continuous variable. Anxiety has also been coded into nonclinical/clinical categories following the authors' suggested clinical cut-off level of one standard deviation above the mean.

The *Children's Depression Inventory* (CDI) is a 27 item self-report questionnaire which samples overt depressive symptoms such as suicidal ideation, sadness, and loneliness. For each item, the child is asked to select one of three statements about the symptom which best describes the child over the previous two weeks. The three statements are coded 0 - 2, keyed to severity. Responses are summed to yield a continuous depression score, and can also be dichotomized into nonclinical/clinical using criteria established by the author and based on normative samples. Reported internal consistency reliability (coefficient alphas) ranged from .80 to .86 (Kovacs, 1981). Scores have been demonstrated to be reliable and stable over a six month period (Tesiny & Lefkowitz, 1982).

The CDI has also been shown to differentiate between children diagnosed as depressed and non-depressed consistent with other measures of depression in children (Kazdin, French, & Unis, 1983). Its validity is further supported by strong correlations with two other self rated scales, the Revised Children's Manifest Anxiety Scale ($r = .65$, $p<.0001$) and the Coopersmith Self Esteem inventory ($r = .59$, $p<.0001$) (Kovacs, 1981), and with another self-report rating of depression ($r = .78$, $p<.0001$) (Reynolds, Anderson, & Bartell, 1985).

The *Child Behavior Checklist* (CBCL) is a widely used 159 item measure of social competencies and behavior problems in children ages 4 through 16 (Achenbach & Edelbrock, 1983). The measure yields a Total Behavior Problem Score derived from the behavior problem

items, eight or nine "narrow band" behavior problem subscales, and two "broad band" subscales: Internalizing Behavior and Externalizing Behavior. The Internalizing dimension is comprised of subscales reflecting anxiety, depression, somatization, and social withdrawal. The Externalizing dimension contains scales reflecting disorders of conduct including aggressive, hyperactive, and delinquent behaviors. For each scale standardized T scores are calculated separately by sex and age. For this analysis, Total Behavior, Depression, Internalizing Behavior, and Externalizing Behavior T scores will be used, as well as clinical cut-offs established by the authors.

Although there has been extensive work on the psychometric properties of the CBCL, more recently, low correlations between child and parent reports and between parent reports and the reports of other professionals have called the validity of the CBCL (and other parent report measures) into question (Achenbach, McConaughy, & Howell, 1987; Everson, et al, 1989). This is an issue that will be examined in this study.

The *Brief Symptom Inventory* (BSI) is a 53 item questionnaire which measures adult psychopathology along nine symptom dimensions: Somatization, Obsessive-compulsive, Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobias, Paranoia, Psychoticism, and Other. Symptomatology can be summarized in three global distress indices: an enumeration of positive items without reference to severity (PST); an index of severity without reference to the number of positive items (PSDI); and the General Symptom Index (GSI), reflecting both the presence and severity of total symptomatology.

High levels of test-retest and internal consistency reliability are reported, ranging from .80 to .90 on the global distress indices. The BSI has also been found to discriminate between clinical and nonclinical samples, and norms are available for normal respondents, psychiatric inpatients, and outpatients (Derogatis & Spencer, 1982).

Because the GSI is reported as the most sensitive of the global distress indices, it is used for this study along with the nine symptom subscales. The scales were used as continuous variables to assess their relationships with the victimization variables. For other analyses the GSI was also dichotomized in ywo ways: into clinical and nonclinical categories using the clinical cutoff value (T scores above 62) established by the authors; and into moderate and extreme categories. Extreme scores were defined as falling below one standard deviation below the mean (<40) or above the clinical cutoff (>62). The moderate/extreme dichotomization was created in order to capture

extremely low scores that may reflect a denial rather than an absence of symptomatology.

Statistical analyses

Maternal and child outcomes and their relation to victimization experiences were described by calculating basic distributions and frequencies of the victimization, demographic, and outcome variables, and by performing bivariate correlation analyses between each victimization variable and each of the maternal and child outcome variables. In order to assess the impact of each victimization variable on each outcome measure, multiple linear regression analyses were performed, first with the victimization variables alone, and then controlling for the demographic variables.

Relationships among maternal symptomatology and maternal and child report measures of child outcomes were assessed through correlation analysis.

Agreement between maternal and child reports of clinical level of child symptomatology was analysed using Kappa statistics. This analysis was first done on the overall sample comparing each of the four maternal report scores with each of the two child report scores. Then, in order to assess the influence of maternal symptomatology on mother-child agreement, the Kappa analysis was repeated stratifying by nonclinical-clinical and moderate-extreme levels of maternal symptomatology.

RESULTS

Emotional and Behavioral Symptomatology in Children and Mothers

Victimization experiences. The abuse experiences of the children appear quite severe. The majority of children are reported to have experienced more than one type of sexual act, with seventy-six percent (37) reported as having experienced oral-genital sex, anal or vaginal penetration.

Duration of the abuse ranged from a single incident to five years, with 61 percent (30) of the sample abused more than once, over a mean duration of seven months. Force was used on the majority of children, with 46 percent (23) physically overpowered and 25 percent (12) threatened with force. The older the child the more likely the use of force ($r=.39$, $p=.007$).

The sample was evenly divided between intrafamilial and extrafamilial abuse, with 31 percent (15) of the children abused by biological fathers or father-figures. Girls were significantly more

likely to be abused by fathers than boys (Fisher's Exact Test, p<.001).

It is interesting to note that the victimization variables were correlated between themselves. Specifically, intrafamilial abuse is correlated with duration (r=.23, p=.0065), and the use of force is associated with severity (r=.50, p<.004). Neither ethnic background nor SES were associated with victimization variables, singly or in combination.

Child symptomatology. On the Revised Children's Manifest Anxiety Scale (RCMAS), 25 percent of the children had scores which fell above the cut-off level for clinical severity in contrast with 16 percent in normative samples. In the multiple linear regression analyses, none of the victimization or demographic variables were significantly associated with anxiety scores, with the exception of age. Older children reported higher levels of anxiety than younger children (r=.30, p=.04).

On the Children's Depression Inventory (CDI), 30 percent of the children had scores that fell above the established clinical cut-off, approximately twice the rate expected in normative samples. None of the demographic or victimization variables examined separately or within a multiple regression model were associated with CDI scores.

On maternal report using the CBCL, symptom levels of 43 percent of the children fell above the clinical cutoff level in contrast with two percent reported for normative samples (Achenbach & Edelbrock, 1983). Furthermore, in contrast with the children's self-report measures, mothers' reports of children's symptomatology on the CBCL do appear to be related to victimization variables. Significant relationships were found between Severity and both Total Behavior scores (r=.35, p<.02), and External scores (r=.29, p<.05). The CBCL Internal score was associated with two of the victimization variables: Force (r=.43, p<.02); and Perpetrator (r=.42, p<.02). Mothers of children abused within the family reported higher Internal symptom levels. The relationships remained, although diminished, when demographic variables were controlled in a multiple linear regression. In multiple linear regression analyses, none of the demographic variables made a significant contribution to the prediction of the CBCL score.

Maternal symptomatology. Mothers reported high levels of symptomatology for themselves as well as their children. The mean GSI T score was 58, eight points above the mean of a normal population, with a standard deviation of 13.63 and a range from 33 to 80.

When scores were dichotomized into nonclinical-clinical categories, 45 percent of the mothers

reported symptom scores above the clinical cut-off level, in contrast with 16 percent in normative samples (Derogatis & Spencer, 1982). When mothers' scores were dichotomized into moderate-extreme, 59 percent fell into the extreme category. Mothers from lower SES levels were significantly more likely than mothers from more affluent homes to report symptoms in the clinical range (r=.40, p=.006). There was no relationship between SES and moderate-extreme categories. Relationships between other demographic variables and the dichotomized GSI scores did not differ significantly from chance.

GSI T scores were not significantly related to the victimization variables. However, when maternal scores were dichotomized into nonclinical-clinical, mothers with clinical scores were significantly more likely to report more severe abuse of the child (r=.31, p<.03), and tended to report more Force (r=.28, p<.06). With scores dichotomized into balanced and extreme, significant relationships were also obtained with both Severity (r=.31, p=.05) and Force (r=.36, p<.05).

Maternal symptomatology on the specific symptom subscales was also examined. Means on all subscales were above normal (50), ranging from Somatization with a mean of 54.9 and a standard deviation of 12.2 to Paranoia with a mean of 60.2 and a standard deviation of 9.8. These scores indicate not only overall high levels of symptomatology, but also that maternal distress is felt across the range of symptomatology categories. SES was significantly correlated with seven of the nine subscales and marginally correlated with the two other subscales. Poorer mothers consistently reported more distress, and white mothers also reported more symptoms of Phobia and Paranoia than minority mothers.

Generally, none of the subscales and victimization variables were significantly related with the exception of Hostility and Severity (r=.30, p<.04).

Connections between mothers' and children's emotional distress

Interrelationships among child outcome measures. Table Two presents a correlation matrix of the maternal and child outcome measures.

Insert Table Two about here

There was no relationship whatsoever between children's self-reported depression scores (CDI) and mothers' reports of their children's symptoms on any of the four CBCL scales. Anxiety was modestly correlated with two of the CBCL scales: Total Behavior ($r=.32$. $p<.05$) and External ($r=.29$. $p<.05$). The two child report measures, in contrast, were strongly correlated with each other ($r=.40$. $p<.01$)

Maternal Symptomatology and child outcome measures. Although mothers' reports of their children's symptomatology and children's reports of anxiety and depression were modestly correlated at best and totally random at worst, extremely strong and consistent relationships were found between mothers' own symptomatology and their reports of their children's symptomatology on the CBCL scales (see Table Two). These relationships were highly consistent across all four of the CBCL outcome scales. Furthermore, the relationship between child reported anxiety and maternal reported CBCL scores disappeared when maternal symptomatology was controlled in a linear regression analysis. In other words, mothers' reports of their children's symptomatology were predicted by their own, rather than by their children's, reported levels of emotional distress.

Although maternal report of children's symptomatology was not related to children's reports of their own symptomatology, a significant relationship was found between maternal and child reported anxiety scores ($r=.35$, $p<.05$).

Variation in mother-child agreement and maternal symptomatology

Agreement of mother-child pairs on clinical level of child symptomatology. To measure agreement between mother-child pairs, scores on all child outcome measures were dichotomized according to suggested clinical cut-off values. Next, eight two-by-two tables were constructed. Each table plotted one of the two child self report scales by one of the four maternal report CBCL scales, as is illustrated in Table Three.

Insert Table Three about here

In cell A both mothers' and their children's scores fall below the clinical cut-off levels. In cell B the mothers' scores fall above and the children's scores fall below the clinical level. In cell C the children's scores fall above and the mothers' scores fall below the clinical level. And in cell D mother-child pairs both report depression symptoms above the clinical cut-off levels. Therefore, cells A and D indicate agreement and cells B and C indicate disagreement. This procedure was repeated for each maternal report by child self-report combination.

The strength of agreement between mother and child pairs was calculated with Kappa statistics for each of these combinations. As expected, no significant correlations were found between maternal and child scores on their respective measures.

Maternal symptomatology and mother-child agreement. The next step in this analysis was to examine the role of maternal symptomatology in explaining variation in agreement between mother and child pairs. Using Kappa statistics, the strength of agreement was calculated separately for mothers in the nonclinical and clinical categories on the GSI. The same analysis was repeated stratifying mothers by the balanced-extreme categories.

For mothers with a clinical level of symptomatology, there was no relationship whatsoever between maternal and child reports of the child's clinical level. Mothers whose scores fell below the clinical cut-off, however, showed better agreement with their children, although only one of the combinations, Children's Depression Inventory and the CBCL Behavior Scale, approached statistical significance (Kappa=.35, SE=.21, p=.10).

When the sample was stratified by moderate and extreme categories, marked differences were seen in agreement between the two groups. Agreement was completely random in the extreme group. In contrast, in the moderate group there was significant mother-child agreement between child reported depression and two of the four CBCL scales: Total Behavior (Kappa=.58, SE=.20, $p<.01$); and External (Kappa=.48, SE=.20 , $p<.05$).

DISCUSSION

Maternal and child symptomatology following disclosure

The findings of this study indicate that both mothers and children suffer considerable emotional distress following a disclosure of child sexual abuse. In general, mothers reported higher levels of symptomatology for their children than did children on self-report measures. These findings might be explained in several ways. For example, they may reflect the lower reliability of self-report measures in younger children. Differences between mothers' and children's scores did not change significantly, however, when six and seven year old subjects were removed from the analysis, even though older children reported higher levels of anxiety.

Another possible explanation is that children under report their emotional symptoms or that mothers over report their children's symptoms. Our data offer some support for the latter. The strongest predictor of maternal reports of their children's symptomatology was maternal symptomatology. Indeed, the modest relationship between CBCL scores and child self-reported anxiety scores disappeared with maternal syptomatology controlled. Maternal reports of their children's symptomatology, then, may more accurately reflect their own rather than their children's emotional states.

Differences between maternal and child measures were also found in their relationships with victimization variables. Although two of the victimization variables, Severity and Force, were related to maternal report measures of their own and their children's symptomatology, no significant relationships were found between victimization variables and children's self-reported syptomatology.

These findings suggest that our current knowledge base on sexual abuse outcomes, which is largely derived from maternal report measures, must be viewed from a critical perspective. Although specific characteristics of their children's victimization maybe associated with greater distress in mothers, there was no evidence in this study that victimization variables, either separately or when entered together into regression equations, explain variation in children's self-reported anxiety or depression.

It has been suggested that emotional functioning following sexual abuse is influenced by many factors, including circumstances surrounding the disclosure, post disclosure events, and the sensitivity of others toward the child during the post-disclosure period (Newberger & De Vos,

1988; Conte, 1987; Finkelhor & Browne, 1985). Although a detailed examination of the events following disclosure is beyond the scope of this paper, the positive relationship between maternal symptomatology and child self-reported anxiety supports this view, and suggests the importance of the nurturing context to the child's emotional well-being following sexual victimization.

Mother-child agreement on child symptomatology

The other major objective of this study was to examine agreement between mother-child pairs and the role of maternal symptomatology in their agreement. Previous research comparing maternal CBCL scores with external reporters' child ratings suggests that some mothers are more accurate reporters of their children's symptomatology than other mothers. For example, as noted above, Everson et al (1989) found that mothers of incest victims who believed in the abuse were more accurate reporters of their children's symptomatology than mothers who were ambivalent or who did not believe that the abuse took place. Although we cannot assume that mother-child agreement as measured in this study demonstrates maternal accuracy, a similar relationship emerged in this study when agreement was compared between mothers who consistently and inconsistently believed that their children had been abused. When mothers were inconsistent in their belief no relationship existed between their and their children's child symptomatology ratings. In contrast, mother-child agreement was substantially better in the consistent group, approaching but not quite reaching significance at the .05 confidence level (Kappa=.421, Se=.232, $p<.07$). This suggests that mother-child agreement may represent at least in part greater maternal sensitivity to the child's experience.

In the aggregate, children's reports and mothers' reports bore virtually no relation to each other. However, when the sample was dichotomized by maternal symptomatology categories, mothers who fell between very low or very high symptom extremes showed significantly better agreement with their children. When the two-by-two tables were more closely examined, it became clear that when mother-child pairs disagreed, the mother was more likely to report symptoms at the clinical level and the child at the nonclinical level than vice-versa. This suggests that disagreement may to some extent reflect maternal sensitivity to child symptomatology that the child might reveal behaviorally, but not on verbal self-report measures. However, all mothers with extremely low symptomatology scores rated their children at nonclinical levels on all maternal report scales. Therefore, when they disagreed with their children, they reported their children's

scores at the nonclinical level while the children reported symptoms at the clinical level. Mothers' own adaptations, then, appear at least in part to predict maternal perceptions of their children's adaptations.

The findings of this study must be interpreted cautiously. The sample is small, limiting the generalizability of the findings. Furthermore, our assessment of mother-child agreement rests on a comparison of ratings on different measures for mothers and their children. Therefore, our analyses provide only estimates of the extent to which mothers and their children share a common perception of the severity of child symptoms.

Given these limitations, however, these data suggest that severe maternal symptomatology is a frequent consequence of child sexual abuse disclosure. Severe psychological distress may compromise a mother's ability to separate her own from her child experience and be an important influence on the child's adaptation following disclosure. Mothers in these circumstances should not be blamed, as is so often the case in the sexual abuse literature. They are victims too, and need sensitive and compassionate interventions in order to help them recover from their own trauma, and in so doing become better able to support the recovery of their children.

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TABLE 1:
OUTCOME MEASURES

MEASURE	MODE OF ADMINISTRATION	VARIABLES
Child Behavior Checklist	Maternal report	Total Behavior Internal symptoms External symptoms Depression scale
Revised Children's Manifest Anxiety Scale	Child self-report	Total Anxiety Anxiety nonclinical/ clinical
The Children's Depression Inventory	Child self-report	Total depression score Nonclinical/ clinical
Brief Symptom Inventory	Maternal self-report	General symptom index (GSI) Somatization Obsessive Int Depression Anxiety Hostility Phobia Paranoia Psychotocism Other

TABLE 2

INTERCORRELATIONS BETWEEN CHILD SELF-REPORTED AND MOTHER REPORTED OUTCOME VARIABLES

	GSI	CBCL Beh T	CBCL Int T	CBCL Ext T	CBCL Dep	RCMAS
CBCL Beh T	.51***					
CBCL Int T	.48***	(see note)				
CBCL Ext T	.41**	(see note)	(see note)			
CBCL Dep	.43**	(see note)	(see note)	(see note)		
RCMAS	.35*	.32*	.28	.28	.29*	
CDI	.09	-.002	-.05	.09	-.08	.40**

* $p < .05$
** $p < .01$
*** $p < .001$
(Note) the intercorrelations among CBCL scores are not shown, as these scores are derived from each other

TABLE 3

MOTHER-CHILD AGREEMENT TABLE

		MATERNAL REPORT CBCL SCORES	
		Nonclinical	Clinical
CHILDREN'S SELF-REPORT DEPRESSION AND ANXIETY SCORES	Nonclinical	CELL A	CELL B
	Clinical	CELL C	CELL D